Updated: 07/2019
PARP Approved: 07/2019

Prior Authorization Criteria

Spravato (esketamine)

All requests for Spravato (esketamine) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of [treatment-resistant depression] and the following criteria is met:

- The member is 18 years of age and older
- Must have a diagnosis of moderate to severe major depressive disorder without psychotic features
- Provider attestation of the following:
    - The diagnosis was made using DSM-5 criteria by or in consultation with a mental health provider
    - Spravato (esketamine) will be used in combination with an oral antidepressant
    - Spravato (esketamine) will be administered under the supervision of a healthcare provider and the member will be monitored for at least 2 hours after administration
    - The member has been assessed and determined not to be at risk for abuse and misuse of Spravato (esketamine)
- If the request is for a new start, documentation showing the member has tried and failed or had an intolerance or contraindication for at least 4 weeks each to at least 2 antidepressants
    - At least one failure must have occurred in the past 3 months
- Documentation of a baseline Montgomery-Åsberg Depression Rating Scale (MADRS) total score.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation the member responded to therapy demonstrated by an improvement from baseline in MADRS total score
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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SPRAVATO (ESKETAMINE)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Treatment Resistant Severe Major Depressive Disorder without psychotic features ☐ Other: _____
(*please provide documentation of how diagnosis was determined)*
Was the diagnosis made using DSM-5 criteria by or in consultation with a mental health provider? ☐ Yes ☐ No
Please select all of the following that apply:
☐ The medication will be used in combination with an oral antidepressant
☐ The medication will be administered under the supervision of a healthcare provider
☐ The member will be monitored for at least 2 hours after each administration of the medication by a healthcare provider
☐ The member has been assessed by a health care provider and has been determined not to be at risk for abuse or misuse of the requested medication
Please provide the member's baseline Montgomery-Asberg Depression Rating Scale (MADRS) score:_____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please provide the member's current MADRS score: _____ Date taken: _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date